DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

November 3, 1998

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

ALL COUNTY INFORMATION NOTICE NO. I-66-98

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: CHANGE ON THE CLAIM FOR REIMBURSEMENT CONTRACT EXPENDITURE (SOC 432) FORM TO IMPLEMENT THE INCREASE IN FEDERAL MEDI-CAL ASSISTANCE PERCENTAGE

This is to inform counties of an increase in the Federal Medi-Cal Assistance Percentage (FMAP) effective October 1, 1998. FMAP determines the federal share of Medicaid benefit costs and establishes the federal share for the Foster Care, Adoption Assistance, Child Support, and In-Home Supportive Services (IHSS) Programs. This increase effects the percentage of federal financial participation for reimbursement for the Personal Care Services Program (PCSP) costs.

The federal sharing ratios will increase from 51.23 to 51.55 percent. The sharing ratios for the non-federal portion of PCSP cost (48.45 percent of the total PCSP cost) will remain at 65 percent for the State and 35 percent for the County. The Non-PCSP sharing ratios for State and County remain the same. We have revised the SOC 432 to reflect this change. A copy of the revised form is attached.

Also, counties contracting for services delivered in the IHSS Program are reminded of the need to forward a letter with sample signatures of the person(s) authorized to sign the SOC 432s. This information allows the state to verify that the appropriate county personnel are certifying and approving SOC 432s, for auditing purposes. The persons authorized to sign SOC 432 are the County Welfare Director or the Contract Administrator and the County Auditor, the County Controller, or their representative. Also, counties should provide a new letter of authorized signatures whenever additional staff or replacement staff will be authorized to sign the SOC 432.

Please feel free to make copies and distribute the revised SOC 432 form or contact the Department's Forms Management Branch, at (916) 657-1984 and request a "Camera Ready" copy. For further information or clarification on the contents of this notice, please contact your assigned Adult Program Operations Analyst, at (916) 229-4000.

Sincerely,

Original Document Signed By
Donna L. Mandelstam 11/3/1998

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Enclosure

claim for reimbursement in-home supportive services program contract expenditures

To: Adult Programs Management Bureau
California Department of Social Services
744 P street, MS 19-96
Sacramento, CA 95814

FROM:
COUNTY:
ADDRESS:
CONTACT PERSON:
PHONE NUMBER: ( )

CONTRACT NUMBER	CONTRACTOR NAME	SERVICE MONTH/YEAR

contract service delivery totals for month by funding source:

WARRANT DATE_____
FISCAL YEAR/QTR. _____

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP					
Non-PCSP					
Totals					

* If the actual PCSP and Non-PCSP adjustment amounts are not known, please estimate the PCSP and Non-PCSP amounts based on the PCSP and Non-PCSP hours to total hours ratio.

cost reimbursement detail by funding source:

FUNDING SOURCE		FEDERAL		STATE/COUNTY		STATE		COUNTY	TOTAL NET EXPENDITURE
PCSP	(51.55%)		(48.45%)		(65%)		(35%)		
Non-PCSP					(65%)		(35%)		
Total									

DO NOT PAY THIS AMOUNT

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR	DATE

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

Approved by: _____ Date _____
(State IHSS Program Manager)

SECTION I OVERPAYMENTS/UNDERPAYMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
A	PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
B	CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
C	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION II OTHER_____ (COUNTY SPECIFIC)

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
D	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
E	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
F	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION III LIQUIDATED DAMAGES

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
G	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
H	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
I	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION IV PCSP / IHSS ADJUSTMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
J	NET ADJUSTMENT C + E + H (+ / =)	(1)	(2)	(3)	(4)	(5)	(6)
K	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
L	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION V CONTRACTOR BILLING

	SERVICE MONTH (1)	TOTAL PCSP CASES	TOTAL IHSS CASES	TOTAL PCSP HOURS	TOTAL IHSS HOURS	TOTAL PCSP GROSS	TOTAL IHSS GROSS
M							
N	INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)
O	NET ADJUSTMENT + / = C + E + H OR L	(1)	(2)	(3)	(4)	(5)	(6)
P	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)